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ABSTRACT

A three-fold exploratory study was conducted to examine the current literature regarding the effects of spousal abuse on observing children, evaluate children's programs within battered women's shelters, and propose a model children's program designed to meet children's needs. Based on the literature and the children's programs currently existing, a model program was developed. Administrative staff in battered women's shelters identified as expert in the field of domestic violence service delivery were interviewed for their evaluation of the proposed model. The experts also identified barriers to implementation of the model and ethnic and cultural issues that affect service delivery. The model children's program was modified as a result of the experts' input. This report describes the development of the children's program and discusses barriers noted by experts in the field, recommendations for overcoming the barriers, cultural and ethnic differences which affect service needs, implications of the model children's program, and recommendations for shelter service providers and future research regarding children's programs within battered women's shelters.
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THE PROVISION OF CHILDREN'S SERVICES
WITHIN BATTERED WOMEN'S SHELTERS:
A MODEL CHILDREN'S PROGRAM

A THESIS
Presented to the Department of Social Work
California State University, Long Beach

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

By Debra Michel Brancato
BS, 1985, California State University, Long Beach
May 1987

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Debra Michel Brancato

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The three-fold purpose of this exploratory study was to: (a) examine current literature regarding the effects of spousal abuse on observing children; (b) evaluate children's programs within battered women's shelters; and (c) propose a model children's program designed to meet these children's needs.

A model program was developed based on the literature and children's programs currently implemented. Administrative staff in battered women's shelters identified as expert in the field of domestic violence service delivery were interviewed for their evaluation of the proposed model. The experts also identified barriers to implementation of the model and ethnic and cultural issues that affect service delivery.

The model children's program was modified as a result of the expert's input. Implications of such a program and

recommendations for the elimination of barriers to implementation are discussed.

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A MODEL CHILDREN'S PROGRAM

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Chapter 1

Problem Statement and Research Questions

Public and professional awareness of problems associated with family violence has increased in the past 10 years. Isolated research has documented what most of us have found through experience; there is a cyclical nature to this type of abuse (Armstrong 1986; Giles-Sims 1985; Jaffe, Wolfe, Wilson and Zak 1986; Stacey and Shupe 1983). Primary prevention needs to focus on children and should include; (a) intervention with children exposed to violence; (b) prevention programs implemented in the school setting; and (c) a general move toward the eradication of sex-role typing that oppresses women and maintains male superiority as the dominant ideology in our society (Stacey and Shupe 1983). Shelters for battered women are in a unique and advantageous position to intervene with children subjected to interparental violence.

This exploratory study focused on shelters as service providers for children in an attempt to answer the following questions: What services are provided to children in battered women's shelters? To what extent are they available? How do cultural and ethnic differences

affect service needs? According to current literature and research, what are the components of an ideal children's service program within a battered women's shelter? And, what are the barriers to implementation of such a program? How can these barriers be overcome?

Chapter 2

Review of the Literature

Carlson (1984, p. 152) identified four types of work that sensitize us to the possible effects of domestic violence exposure on children:

1. Literature on the relationship between physical and emotional problems related to stressors such as divorce and general marital discord.
2. Retrospective studies of adults which assess violence within their families of origin.
3. Anecdotal reports describing children of violent homes.
4. Research studies on children from homes where interparental violence has occurred.

In addition, this study considers reports and research which examine children exposed to parental violence who were also victims of abuse themselves.

Part 1: Children, Stress Factors and Domestic Violence

The profound effects of parental separation, and divorce on children is well supported in the literature (Hess and Camara 1979; Wallerstein and Kelly 1980). Both spousal violence and nonviolent marital discord, expose children to common stressors: arguments between spouses,

abrupt school changes, inadequate child management and general parental hostility--often related to behavioral and emotional problems exhibited by children in these homes (Hershorn and Rosenbaum 1984; Jaffee and others 1986). A major study of children and young adults, found negative life events requiring moderate readjustment associated with dysfunctional behaviors such as: fighting, anxiety, parent/child problems and delinquency (Gersten, Langner, Eisenberg and Orzeck 1974).

Further, Jacobson (1978) found a significant relationship between parental hostility and children's somatic complaints, aggression, withdrawal and numerous fears and insecurities. Basically, the more volatile the parental hostility, the more adjustment difficulties noted in offspring. Even devoid of excessive hostility, children of all ages subjected to parental separation experience extreme sadness, loss, anger, guilt and concern about current nurturance and future living and visiting arrangements (Campbell 1986, p. 46).

Research Studies on the Effects of Domestic Violence

Most of the literature examining the effects of exposure to spousal violence has been accomplished through retrospective studies. For instance, Roy (1977) found violence in families of origin in 81% of her abusive husbands and 33% of her abused wives. More recently,

Forsstrom-Cohen and Rosenbaum (1985), studied college students who had witnessed parental violence and compared them to students whose parents had satisfactory relationships, as well as students who came from homes where there was nonviolent marital discord. Students were eliminated who were victims of abuse themselves. Forsstrom-Cohen and Rosenbaum (1985) found that males and females were affected differently. Increased levels of anxiety were noted to occur for both males and females; however, only females showed elevated levels of depression and aggression. The results of this investigative report, therefore support the conclusion (Carlson 1984; Walker 1979) that exposure to parental marital violence negatively affects the witnessing children persisting into adulthood.

Forsstrom-Cohen and Rosenbaum's (1985) findings of increased depression in women from marital violent homes is also consistent with the helplessness model of wife abuse by Walker (1979). Walker proposes that female children exposed to the abuse of their mother by their father, model their mother's helplessness to control their own lives--promoting depression in those children who identify with their victim mother. Walker also proposes that males who witness parental violence are more likely to identify with the aggressive father rather than the victim and, as a result, avoid depression.

As well, Rosenbaum and O'Leary (1981) found a significant tendency for husbands who had witnessed parental violence to repeat the abusive dynamic in their adult relationships. The results of their study, at the same time indicated that abused wives were not more likely to come from homes where parental violence occurred, anymore than nonabused comparison groups.

Children frequently witness their parent's violence and are often used as pawns in arguments (Department of Health, Education and Welfare [DHEW] 1980). This exposure to violence for children can be manifest in different ways. For example, studies have found exposure to spouse abuse related to a variety of child problems including: lower school performance, fewer social activities (Wolfe, Zak, Wilson and Jaffee 1986), anxiety disorders, truancy, aggression (Levine 1975) and low self-esteem (Hughes and Barad 1983). Jaffee and others (1986) examined the impact of domestic violence on witnessing school-age boys and compared them to boys who had been abused. The findings indicate that boys exposed to violence have adjustment problems similar to those of abused boys. Both groups differed in severity from children of nonviolent families.

Child Witnesses and Victims of Domestic Violence

The most comprehensive study of children in shelters was done by the National Center on Child Abuse and Neglect

(NCCAN); conducted by Layzer, Goodson and deLange (1986a; 1986b). The findings are very supportive of the need for children's services within domestic violence shelters. They found that nearly 70% of the children who came to shelters were victims of abuse or neglect. Almost half were physically or sexually abused. Most were emotionally abused and physically neglected. Five percent of the children required hospitalization because of the abuse incurred. Sexual abuse was noted in 8% of the children. Layzer and others (1986b) felt this was a low estimate since caseworkers indicated they did not have specific knowledge of sexual abuse. Consequently, it was found the longer the family stayed in the shelter the more likely workers were able to identify sexual abuse problems.

Supportive of the NCCAN study, research by Truesdell, McNeil and Deschner (1986, p. 140) suggests that wife abuse is more common in families in which incest occurs than in the general population. Furthermore, an analysis of a nationally representative sample of American families found a 129% greater chance of child abuse in homes where wife abuse occurred (Straus, Gelles and Steinmetz 1980). Additionally, they suggest that children who are direct or indirect victims of domestic violence may overlap by almost 40%.

In the study conducted by Layzer and others (1986b, p. 3), the batterers were held responsible for most of the

abuse. In a few cases the mother was the only abuser. The mother and batterer were jointly responsible for 24% of the emotional abuse and 21% of the sexual abuse. Children were sexually abused by others in a third of the sexual abuse cases. Giles-Sims (1985, p. 209) findings were suggestive that battered women who seek refuge from the batterer may abuse their children less frequently than abusive parents in a random sample. However, those women who do seek refuge may have partners who abuse the children much more frequently than abusive parents in a random sample. Despite all the abuse, most of the families had never been involved with protective service agencies, and only 20% of the families were currently being seen by them (Layzer and others 1986b).

Children in Shelters

Alessi and Hearn (1984) treated children and their families who were residing in shelters in a multifamily group. Observations of these children have demonstrated that there are characteristic ways children react to the transition of coming to a shelter (Aiken 1981). For instance, during altercations with each other children were observed initially solving their problems by hitting. Seemingly unaware of alternatives, not only were they aggressive with each other, but with other adults, animals and inanimate objects. Their language was found abusive

and they tended to blame others for their own mistakes. Additionally, some children experienced regressive symptoms such as school phobia, enuresis, somatic complaints, nightmares and insomnia (Hughes 1986). Equally important, Layzer and others (1986a) found that among the infants more than half had health problems. Children known to be abused and neglected were noted to have higher incidences of all the problems.

Hughes (1982) found that all of the children in her study were emotionally needy--yet expressed it in different ways. Younger male children were likely to act-out, become disobedient, and at times defiant and destructive. In fact, boys reportedly exhibited violent behavior by age three (Hughes 1986). Usually the male child between the ages of 6 and 11 missed his father more than his sister did. Hughes saw this as conflictual for the child since their father was often the subject of criticism by residents in the shelter. As a result, some boys requested that they be allowed to join their father (Hughes 1982). In contrast, young girls were more likely to withdraw and become clingy and dependent on their mothers.

One study compared the psychological functioning of children in shelters to normative groups (Hughes and Barad 1983). It was found that older school-age children scored average on measures of self-esteem; younger school-

age children scored at the lower end of the average range; and pre-schoolers were well below average. Overall, pre-schoolers appeared to have the greatest adjustment problems (Hughes 1986; Hughes and Barad 1983).

Rhodes and Zelmen (1986) found that often mothers did not tell their children why they came to the shelter. When given the opportunity, children were able to discuss their fears. In a description of a multifamily session they had facilitated, a five year old child shared her experience. She recalled having trouble sleeping while her mother and father fought. She feared "daddy would kill her mother and then kill her and her siblings" (p. 123). Even very young children have their own way of expressing their feelings. Rhodes and Zelmen describe another session where an 18 month old child continuously rode a toy car in and out of the room. As the child left he'd say "bye bye daddy" as he returned he'd say "no daddy." The leader commented to the mother about the many goodbyes the child might have experienced recently (p. 124).

Aiken (1981) sees children coming to shelters as suffering from two sets of stress factors--shelter related and personal. She identifies shelter stress factors as: living in a new environment; living cooperatively/sharing; lack of personal space; introduction to many new people; change in diet; change in discipline; the influence of

other residents stress levels; new rules; and fear of the unknown. Personal issues for children include: loss of a parent, possessions and friends; age-related anxieties; guilt in causing the violence; guilt about wanting to play; divided loyalties; confusion; and low self-esteem. Aiken feels also that many of the behavioral changes that occur with children from violent homes are manifestations of internalized guilt, anger, anxiety, depression, or fear.

Cultural and Ethnic Considerations

Domestic violence pervades every race, ethnic group, religion and economic class (Del Rio 1986; Su Casa, no date). Cultural and subcultural factors in relation to domestic violence, however, appear to have received little attention (Long 1986, p. 131). Yet cultural factors may play a significant role in planning intervention strategies for children and their mothers. Long describes, for instance, attitudes of Native Americans in Montana that overlap with those of white rural town dwellers.

Striking a spouse on the face may be seen as acceptable so long as no permanent disfigurement occurs . . . even extreme forms of abuse may be considered acceptable if they are in response to certain actions on the victim's part such as disrespect toward an elder. (Long 1986, p. 132)

Other studies, though not empirical, have noted impressionistic commonalities in the various cultural groups. For example, in Asian families, the instillment

of guilt and shame are techniques used to control behavior of family members. Parents emphasize their children's obligations to the family. Therefore, domestic problems are generally kept hidden from public view (Sue 1983, p. 86). In the Vietnamese culture, children are taught to conceal antisocial emotions such as anger and hostility, and not question authority--especially the father's (Brower 1983, p. 113). McGlaufflin (as cited in Dunwoody 1983, p. 2) believes that violence in Indochinese refugee families is activated by the extreme stress and drastic changes that accompany the refugee's relocation to a new country--factors such as these need to be taken into consideration. And finally, rigidly defined sex roles in Hispanic cultures may hinder intervention with these groups if those intervening are not culturally sensitive (Padilla, Ruiz and Alvarez 1983, p. 191).

Layzer and others (1986b, p. 4) collected demographic information on mothers and their children residing in shelters. While they did not specifically collect data on cultural background, they did examine the ethnic and economic characteristics of the women involved. Half were reportedly Caucasian, a third were Black, and about 10% were Hispanic. Asian and Indian women were also represented. In general, the cultural and ethnic populations of the shelter reflected the location of the refuge.

Many of the mothers were reportedly poor. Annual incomes were usually less than \$8,000. Approximately 15% of the mothers had annual incomes of at least \$16,000. Besides being poor these families suffered multiple stresses--they were socially isolated and had heavy child care responsibilities. Often batterers had problems with drug and alcohol dependency, addictions associated with domestic violence frequently in the literature (Doczi no date; Martin 1976; Weidman 1986).

The Need for Children's Services

The literature supports the need for children's services within domestic violence shelters. In order to provide comprehensive services, shelter staff need training in: identification and treatment of child abuse (Layzer and others 1986a; 1986b); the dynamics of child development; and cross-cultural issues relative to childrearing practices and communication styles. A working relationship with child protective service agencies is essential. Furthermore, psychosocial and educational services need to be available on a regular basis in shelter settings with special consideration given to those children who have been abused.

The welfare of the children can be further enhanced through on-going support of their mothers via parenting programs, ex-resident programs (Layzer and others 1986a,

p. 11) and provision of child care. And finally, because of the extensive abuse these children are subjected to and the nature of their complex medical problems, the need for a mandated medical examination while residing in a battered women's shelter is apparent.

part 2: Services for Children
in Domestic Violence Shelters

The majority of women seeking shelter services have two or more children accompanying them. Most shelters accept children, though services provided for them vary and are dependent on the availability of resources, staff and length of stay of the families (King 1986, p. 11).

The National Coalition Against Domestic Violence (NCADV) lists approximately 872 of these shelters (1986) in their 1986 National Directory of Domestic Violence Programs. Of these, 529 shelters had indicated that they offered "Children's Counseling/Programs" (p. viii). Children's counseling/programs refers to:

One or more of the various types of services provided for the children of battered women--ranging from counseling, to advocacy, to recreational activities, to a structured children's program. (NCADV 1986, p. viii)

This definition of "children's counseling/programs" leaves much room for interpretation. When used, it is difficult to ascertain what services are actually offered, or for that matter, what the guidelines may be for developing such a program.

This section will describe current children's services available in battered women's shelters. Most of these programs were developed by shelter staff in response to identified child abuse (King 1984). In recent years, they have expanded to include teaching children and their parents nonviolent ways of relating to others. There are only a few resources available which describe these programs in comprehensive detail: " . . . and then we went to a safe place" A Training Manual for Children's Services in Battered Women's Shelters (Hughes, Gundy, Walker, Beebe, Sullivan and Manire 1981) was developed out of the experience of staff at a children's program in Fayetteville, Arkansas. It is one of the most complete resources to date. The following pages describe components of the training manual as well as other children's services presented in the literature.

Initial Interview

Most shelter programs allow an adjustment period upon the family's arrival (Aiken 1981; deLange 1986; Doczi no date; Hughes and others 1981). Besides assessing their immediate medical needs, staff assist them in acclimating to the shelter.

The initial intervention, with mother and child, occurs within 24-72 hours, depending on the shelter's policy. It may consist of: (a) general information

gathering regarding the events leading up to the mother and child's arrival at the shelter; (b) completion of a health inspection form; (c) orientation to the shelter facility; (d) explanation of the shelter rules (e.g. "no hitting"); (e) rapport building between child and staff; and (f) the assignment of an advocate to the child involved. Again, since most children come to the shelter in crisis an important aspect of the initial interview is to assess their immediate needs and assure them of their safety.

Child Intake

Within 24-72 hours of a family's arrival at the shelter, a staff member arranges to meet with the mother and child again. A history of the child is completed with mother present. An interview with the child alone is preferred once trust is established and the child and parent are comfortable with this type of arrangement. A plan is developed relative to each child's psychosocial and educational needs. The possibility of abuse is assessed and medical and child care release forms are filed (Aiken 1981).

Program Curriculum

Children's programs differ in their approach to intervention with children. A predictable daily schedule is preferred by most, especially for pre-schoolers (Hughes

1982). The following is a list of regular activities offered for children through various shelter programs. They include: (a) game activities; (b) structured therapeutic group activities to encourage expression of feelings; (c) age-appropriate support groups for children; (d) scheduled wake-up, nap, meal, and snack times; (e) allotted time with a regular worker or volunteer staff person acting as the child's advocate; (f) quiet time at the shelter for studying or pleasure reading; (g) provisions for structured and unstructured play; (h) field trips; and (i) regular support services for parents designed to promote positive childrearing practices and healthy interaction between family members (Aiken 1981; deLange 1986; Hughes and others 1981).

Psychosocial Intervention

Therapy/counseling services are dependent on staff availability and resources within the facility (Hughes 1982). The preference for group treatment is influenced by several factors: (a) the transient nature of the families involved; (b) wide age-range of the children; (c) shortage of shelter staff able to provide individual treatment; and (d) facility shortcomings inhibiting the implementation of such services. For these reasons Alessi and Hearn (1984) feel that group treatment is the treatment of choice.

Their short-term model focuses on the crisis and provides the children with information and problem-solving skills that can assist them when they leave the shelter. Rhodes and Zelman (1986) propose a multifamily group that includes all child residents in the shelter and their respective mothers. For some programs, this was the only intervention for children provided. The effectiveness of this treatment mode is questionable particularly if it is the only clinical service offered. It is doubtful whether a child would choose to disclose information about abuse she or he experienced, especially if the perpetrator was the mother.

Small groups of 4 to 5 children are preferred at the Haven House Shelter (Doczi no date). Small groups reduce the chance of bickering among participants and allow for individual attention. When availability of staff allows, individual sessions are desirable. Male staff are preferred for intervention with boys to serve as positive role models.

Educational Services

A majority of shelters collaborate closely with local schools, allowing the mother and child hassle-free enrollment. It also ensures attempts to take the children by the father do not occur as staff are informed about temporary restraining orders in effect and details

regarding the transportation of children to and from school (Hughes 1982). Sensitization of school staff about the special needs of children residing in shelters is important. Hughes (1982) found that junior and senior high school students have significant trouble with peer pressure, and social cliques when entering school. Based on this experience, shelters may opt to arrange for an alternative school setting or not require attendance at all. An alternative setting was not elaborated on by Hughes (1982).

In Toronto, Canada, a special class has been established in a local public elementary school for children who are staying at shelter facilities in the area (King 1984). The special class is designed to assist children deal with their personal crises and learning difficulties. In this setting there is one staff member for every four children which allows for individualized attention and room to talk about feelings.

Cooperative Strategies: Networking

Cooperative relationships with outside community agencies complement those services for children the shelter is unable to provide or needs assistance implementing. For example, clinical intervention services may be jointly facilitated with therapists from outside agencies and staff at the shelter (Alessi and Hearn 1984).

Additional cooperative relationships with outside agencies have included: Headstart programs, health facilities, child protective services, therapeutic day care programs, community psychological services, Big Brother and Big Sister Programs, and clinical programs in local universities, utilizing students in psychology and social work programs (Aiken 1981; deLange 1986; Hughes 1982).

Other Services

Other services offered at shelters adjunct to their regular children's program: (a) alcohol and substance abuse prevention; (b) a comics group; (c) toy loan; (d) dental check-ups; (e) parenting classes for mothers; (f) child care during parenting groups; (g) telephone contacts from volunteer advocates; (h) weekly progress sheets kept on children seen at the shelter; (i) tutoring; (j) transportation; (k) accompaniment; (l) indoor and outdoor play opportunities; (m) child development education; and (n) follow-up services. These services too are dependent on the availability of staff and resources at hand in the shelter.

Staff Titles and Positions

Shelter staff in the children's programs presented here are as diverse as their services. Some titles given shelter staff working in children's programs are: (a) child advocate; (b) family services coordinator; (c)

clinical supervisor; (d) child counselors; (e) children's program coordinator; (f) group advocates; (g) tutor; (h) male children's advocates; and (i) volunteer staff.

Actual titles of workers within these programs is unimportant. What is relevant is the provision of services and staff available to implement them. Equally important is staff knowledge of normal child development, family dynamics, and clinical intervention (Hughes and others 1981).

A Discussion Regarding Shelter Intervention Programs With Children

Overall, shelter programs described in the literature provide a variety of services to children. However, according to NCADV (1986) only 60% of shelter programs actually offer any type of children's program. The recent discovery of extensive physical abuse, sexual abuse and neglect of children accompanying their mothers to shelters has forced service providers to alter the focus of their programs away from just the mother. As a result, shelter staff have ethical, legal and professional obligations to these young clients not apparent previously. The standardization of children's services designed to protect the welfare of these children is essential.

Chapter 3

Methodology

After reviewing the literature on children's services within battered women's shelters, a model children's program was drafted. The proposed model (Appendix A) was divided into eight components; each component was defined by the services it offered. Depending on the services provided, the model demarcated the optimal, desirable, and minimal service program, as indicated on the model program checklist (Appendix B).

Participants

Administrative staff at ten battered women's shelters were identified as expert in the field of domestic violence service delivery. Seven experts actually participated in the study. Four were executive directors and three others were children's program directors/coordinators. Six shelter programs were located in Southern California. These six represent approximately 12% of the total California shelters offering children's programs (NCADV 1986). One shelter in Dallas, Texas was chosen because of its involvement in one of the most comprehensive studies of children in shelters (Layzer and others 1986a; 1986b). Participants were further selected

based on: (a) their shelter's provision of children's services; (b) ethnic and cultural population served; (c) the size of their program and number of staff available to provide extensive services (NCADV 1986); and (d) the researchers experience in domestic violence and sexual assault service delivery as well as the shelter's reputation for providing services in the Southern California region.

Three of the ten administrators did not participate. Because of financial difficulties, one was forced to close its shelter. Two additional experts declined involvement in the project.

Instrument

A packet was sent to each participant containing: a draft of the components within the proposed model (Appendix A); a draft of the model program checklist (Appendix B); and instructions to the participants (Appendix C).

Data Collection

Six of the experts were interviewed by phone and one in-person in interviews lasting 45 to 70 minutes. Each section of the program was reviewed with participants for their input and recommendations as well as an understanding of the children's services they currently

provide. Once the program draft was reviewed, a list of questions (Appendix D) was asked of each participant.

Chapter 4

Results

Seven administrative staff in domestic violence shelters were interviewed for their evaluation and recommendations of a proposed model children's program.

Experts' Evaluation of the Proposed Model

The proposed model children's program was generally well received. On a continuum, comments ranged from "it's a good model" to "excellent . . . this would be heaven." Assessment of the various programs within these shelters revealed that no program was able to provide all services proposed. A few however, were implementing innovative services of their own, not proposed in the model. The following pages present the experts evaluation of components within the proposed model; barriers to implementation of the model program and; cross-cultural and ethnic differences which affect service delivery.

Medical Exam

Of all the components within the proposed children's model, the medical exam was the most controversial. In none of the shelters was it a policy to have the child at some time during the shelter stay be examined. A majority

(6) indicated the service was very needed but had reservations about the way it was proposed. They all felt it was unreasonable to expect a health examination to be completed within 24 hours unless the child had a medical emergency.

Several expressed it would be traumatizing to a child to be examined without first receiving counseling. Another agreed that the sexual abuse exam could be traumatizing, but also felt information regarding the sexual abuse of a child could be gathered through other means such as counseling and play therapy. Two participants expressed how the health of the child was "the mother's responsibility" and that shelter staff could only recommend she get the child a medical exam. Three were concerned about the ethical implications of mandating such a service. Interestingly enough, one shelter had no trouble mandating drug testing of women residing in the shelter who had prior histories of drug abuse. Minimal health assessments are done in all the shelters through completion of health screening questionnaires.

On a more positive note, two shelters were able to establish arrangements with local well baby clinics. Three shelters, years prior, has cursory exams available on the shelter site. Today these shelters refer women and her children to outside agencies.

Despite opposition to certain aspects of the medical

component, most (5) thought they would optimally want it. Modification of the medical services proposed would take into consideration the possible traumatic effects an exam for sexual abuse may have on a child not suspected of being victimized. Accordingly, a thorough medical exam (within 48-72 hours) on the shelter site would optimally be preferred. And finally, when deemed necessary, via interviews and/or disclosure, a separate exam for the identification and treatment of sexual abuse would be carried out according to CPS guidelines.

Child Abuse Assessment

According to the participants all of the shelters were able to provide some form of child abuse assessment. Once again, most found the 24 hour time frame to be premature and emphasized the need to establish trust and rapport before delving into this type of information with children. All desired a closer relationship with CPS. One administrator's comment was "now if they could only get their act together." Generally, all felt the child abuse assessment component was necessary.

Psychosocial Services

The need for therapeutic services was agreed upon by each of the participants. However, only a few were able to provide all the services proposed. Several had reservations about having men involved in their program

because of the general hypersensitivity toward men in the shelter. On the other hand, two shelters have been quite successful utilizing male staff in their children's programs.

Additionally, abused children within these shelter settings often receive special therapeutic services. For instance, three shelters contract with clinical professionals who provide on-going services for the abused children during their stay in the shelter. Those children not abused are most often seen in group activities. Overall, it was felt that the provision of clinical services reduces the trauma of coming to a shelter and also gives children an opportunity to express their feelings about recent transitions in their life.

Educational Services

All but one of the shelters collaborated with local schools, enrolling children regularly. The one shelter which did not, provides a school classroom on-site with a credentialed teacher. This service was preferred because it was felt enrolling children in school was too risky. Pre-schools on-site, however, were available in a majority of the programs and staffed by employees or mothers residing in the shelter. For those agencies enrolling children in public schools, mainstreaming was preferred over placement in special classes, except of

course, for those children with known learning difficulties and serious emotional problems.

Advocacy and Follow Up

All the participants strongly support the services proposed within this component. For those not yet providing these services, it is a long term goal.

Strengthening Parents: Support Services

Most services proposed in this component, except for post-resident support groups and on-site child care, are currently being implemented in the participant's shelters. Some felt this component was not emphasized enough, the argument being that without parental support services, children's services may not be as effective.

Innovative programs offered by some of these shelters targeted the mothers involved. For instance, a Pacific-Asian shelter, in an effort to promote economic independence from the batterer, offers a special women's entrepreneur program for Vietnamese mothers on welfare. It is a federally funded program designed to train these women how to start their own child care business. The ultimate goal is elimination of their need for welfare. Unfortunately, the program is funded for Vietnamese women only. Another federally funded program "Project Self-Sufficiency" assists battered women, who have low incomes

or are on welfare, in getting second stage housing--almost immediately.

None of the shelters are able to provide child care since they are not licensed facilities. However, this is an aspiration of one of the experts who feels the lack of low cost child care continues to force many women to be economically dependent on the batterer in her life. Ideally, she suggested, a child care program would accommodate ex-residents' children as well.

Facilities

All participants desired a facility as presented in the model. Additional suggestions included: handicap accessibility and an area for children that would meet day care licensing requirements. Of the shelters accepting boys over 12, only one actually had a separate room for boys supervised by a male staff member. Other boys over 12 were either not permitted in the shelter, had to sleep on the couch, or stayed in the same room with their family.

Other Services

The experts highly supported this component of the program though few were able to say they actually employed three of the services regularly. An interesting service provided by two shelters is an infant stimulation group. Volunteers spend 2 to 4 hours daily with the infants,

holding and talking to them. One of the shelters utilizes a foster grandparent program to carry out the service; the other, students in a child development program. Other services provided in the participants' shelters which are not in the proposed model: (a) alcohol awareness programs for children; and (b) recreational outings for children each week.

Chapter 5

Discussion and Implications

The following sections will discuss: (a) barriers noted by the participants; (b) recommendations for overcoming the barriers; (c) cultural and ethnic differences which affect service needs; (d) implications of the model children's program; and (e) recommendations for shelter service providers and future research regarding children's programs within battered women's shelters.

Barriers

The first barrier noted by all of the participants was funding. Administrators claim they are constantly concerned about fundraising efforts. According to the participants, grant sources do not want to fund basic operational needs as much as they do innovative projects. One expert commented on the extent of child abuse intervention shelters are involved in--yet they are still unrecognized by child abuse funding sources.

A second barrier identified was the shortage of staff. Many staff in shelters provide multiple services, and the burnout rate is high. Experts indicated that with the availability of financial resources the staff needed could be easily hired. On the other hand, an administrator

was concerned about the need to maintain a balance of professional and paraprofessional staff. Once again, this comes back to funding. Many of the participants utilize volunteers for implementing components of their children's program. Besides cutting down on costs, many volunteers and other paraprofessionals are those who have successfully left violent situations. They become important role models for women coming to the shelter for the first time.

In order to implement the model program as proposed, experts felt expanded space was needed. Participants desired a location where neighbors would not be offended by the noises of children playing. Child care facilities and room to accommodate male boys over 12 was often unavailable.

The final barrier noted by experts was the lack of resources for medical examinations. According to three Los Angeles County area participants, even when it is determined a child has been sexually abused, children utilizing county facilities in some cases have to wait two weeks to get an exam for collection of evidence (even with CPS involvement). Furthermore, local hospital emergency rooms and clinics not funded by the county, are reluctant to treat clients from battered women's shelters because they rarely get reimbursed for their services. Few of these families have insurance or medicaid cards.

As a result, resources for these women and children are scarce.

Overcoming the Barriers

Battered women's shelters as well as rape crisis centers evolved with the women's movement, originally as grass roots organizations independent of bureaucracies. They were spearheaded by community members who were driven by a passion to empower oppressed women. Initially, their feminist values influenced their financial independence from local, state, or federally funded agencies. As the demands for services increased, and lobbying efforts prevailed, communities became more sensitive to the plight of battered women. As a result, bureaucratic agencies created funds to support battered women's shelters. Shelters feeling the financial burden began to apply for this support. Today, funding to these agencies has improved, though their availability cannot be depended on year to year. In California, the recent fee added to the purchase of marriage licenses has provided some consistent money.

As mentioned previously, the recent discovery of extensive physical abuse, sexual abuse and neglect of children accompanying their mothers to shelters has forced service providers to alter the focus of their program away from just the mother--creating a need for children's

services. It is suggested that shelters lobby for money from funding sources already providing financial support to shelters, as well as those funding child abuse intervention and prevention programs in order to gain the financial back-up children's programs need. With the high incidence of child abuse in families where interparental violence occurs, child abuse funding sources could almost be guaranteed their money would be utilized effectively. As well, these funding sources would be contributing to the primary prevention of future abuse--a long term investment.

Inadequate financial support creates many barriers to program development. Particularly in nonprofit agencies, service providers need to be creative in their funding efforts. Margaret Dunkle (1981, p. 1) says that relatively few family violence programs have tapped corporation or corporate foundation funds. She admits that obtaining this funding is difficult "but not impossible." In her pamphlet Cracking the Corporations: Finding Corporate Funding for Family Violence Programs, she explains in detail how to approach corporations for funding.

Furthermore, Pfouts and Renz (1981, p. 455) propose three survival techniques which assist boards and administrators in maintaining domestic violence programs. The first is the forming of alliances with existing

agencies such as YWCAs. Many shelters have successfully done this. The second is the development of more professional standards of operation. This would include a strong board comprised of power brokers from the community as well as the strengthening of agency practices such as: accounting, record keeping, evaluation, in-service training, personnel procedures and fundraising expertise. And the third survival technique presented is the careful consideration of a change from a one-issue focus on family violence to a multi-issue focus as a way of targeting new funding sources. It becomes a risky venture however, when agencies spread themselves too far away from their original purpose.

The barrier to the provision of medical treatment of children in shelters may be overcome by approaching nursing programs, medical schools, and physician assistant programs in order to establish service agreements between these providers and shelters. Secondly, a close relationship with victim-witness assistance programs may ensure reimbursement of services provided by outside agencies. For California, a pioneer in services to victims of crime, it has been quite successful. The problem with this however, is that the client must show that they have reported the crime and have been cooperative with the state in prosecuting the person before they are reimbursed for damages incurred. Even

when approved, the actual reimbursement is not seen for eight months to over a year, and there is usually a maximum one can receive.

Overall, federal funding for social services has been a problem for some time now. For social service agencies to exist they need to develop their fundraising skills. Medical care is a problem in our larger society as well. It is essential that collaborative efforts are made with community agencies and members, to sensitize them to the medical needs of children coming from violent homes. An ultimate goal being the establishment of a medical protocol for the welfare and well being of these children.

Cultural and Ethnic Differences Which Affect Service Needs

Staff in shelters housing Asian, Hispanic, Black and Caucasian families, shared with the researcher their observations of these populations in the shelter setting. Though participants acknowledged that each adult and child needs to be treated as an individual, they were able to note commonalities of peoples from similar cultural and ethnic groups.

A participant employed in an Asian-Pacific shelter found that many of the Asian women and children have trouble talking about what actually happened to them. There is much shame and therefore it takes more time to

develop rapport with the family members. Women from these families have, on the average, four children accompanying them. One will often find that these families prefer to sleep together "no matter what you say to them" which poses problems when one tries to separate the older boys in the family from the rest of the members. In a significant amount of the Asian families, extended family members live together. Particularly in the Filipino families, the participant felt, one has to consider extended family members as the abuser of the children--not just the mother or father.

Participants working with Hispanic families commented on how mothers often defer to their oldest male child. They may cater to him and rely on his decisions. These male children are resistant to counselling especially if they have bought into the "machismo" concept of being cool and in control. Showing weakness or crying is unacceptable.

Another participant talked about the Latina who has recently left her barrio. She often feels out of her element in the more suburban shelter setting. As one participant said "they are very unaware of resources available to them." Moreover, undocumented women fearing deportation are reluctant to seek medical help and other social services offered.

Mostly it was felt that the dynamics of battering are the same in all cultures. However, methods of child rearing vary and what appears to be abusive and punitive in American culture may be acceptable for certain other cultures. Not much different from our mainstream society, most of the families had different expectations for boys and girls. This often poses special challenges to staff members in parenting classes.

And finally, one participant felt that cultural differences really were not significant. She commented, that generally it was stressful for anyone to live in an environment with other people one may not say hello to passing on the streets. Sharing bathrooms, living quarters, eating foods one is not used to eating, and contending with other individuals customs takes some adjusting.

In summary, that these cross-cultural women come to a shelter at all makes them unique from their sister counterparts who are also battered, and because of ethnic or cultural influences may never utilize a battered women's shelter. What we have to look at more closely is whether we are reaching women and children from these cross-cultural groups who are not utilizing the resources available to them. Furthermore, the United States is a haven for people from all cultures and the awareness of this by service providers is important. When examining child rearing practices and methods of discipline, Jill

Korbin (1981, p. 5) in her book Child Abuse and Neglect: Cross-Cultural Perspectives, recommends that service providers "be aware of the socialization goals of the culture, parental intentions and beliefs about their actions, and the way a child perceives his or her treatment." In order to do this effectively, it is essential that service providers in battered women's shelters be provided with a broad knowledge base on the cross-cultural considerations of battering as well as child abuse and neglect.

Implications for the Model Children's Program

The proposed model, evaluated by experts, was revised to accommodate recommendations and suggestions by the participants. This model program (Appendix E and Appendix F) is a comprehensive approach to meeting the needs of children accompanying their mothers to domestic violence shelters. Additionally, the model serves as a primary prevention effort by intervening early in a cycle known to perpetuate violence.

The model brings to our attention a number of issues. First, it recognizes the incidence of child abuse in homes where there is interparental violence, forcing service providers to alter the focus of their programs away from just the mother. It is important to realize this change in program focus might deter women from seeking refuge,

particularly those women who have abused their children. For this reason, it is also vital that issues such as these be handled sensitively and that women be encouraged to involve themselves in programs to reduce their chances of revictimizing their children (e.g. Parents Anonymous).

Secondly, it recognizes that implementation of the model children's program could have a significant impact on the early detection, intervention and primary prevention of child abuse, a service in the long run which could prove to be quite cost-effective. The multi-impact of a children's program such as this also acknowledges the change in funding emphasis that would eventually occur. Targeting child abuse funding sources is the next step in gaining financial support of children's programs.

Thirdly, the model recognizes that access to medical treatment is a problem for shelter populations as well as nonshelter residents. There is a general assumption that individuals have some type of medical coverage. As a result, standard medical procedures are lacking for children coming to shelters. It forces service providers to say it is the parent's responsibility for getting their children treated--even when it is known 70% or more of the children coming to shelters are abused or neglected (Layzer and others 1986b, p. 2). Therefore, medical treatment for those mostly abused children should be paramount. In order for service providers to fulfill

their ethical, legal, and professional responsibilities, in the best interest of the children, a medical protocol needs to be established.

Finally, the program recognizes the need for the expansion and standardization of women's programs within domestic violence shelters so women may effectively care for their children. For instance, the provision of second stage housing, job training, and low cost child care are essential in assisting the women in remaining economically independent of the batterer as well as help her provide a safe environment for her children.

Recommendations to Shelter Service Providers

It is recommended that shelter service providers:

1. Document the amount of child abuse assessment, detection, and intervention they are involved in on a daily basis, in order to validate the need for additional funding to support these children's services.
2. Approach child abuse funding sources for financial support to implement comprehensive children's programs.
3. Network with local, state, and national domestic violence councils to establish a medical protocol for children coming to shelters.
4. Network locally with community agencies to ensure, through a collective effort, comprehensive services are

established for children coming to shelters.

5. Utilize the model children's program as a guideline for shelters not currently providing children's services, or those wishing to improve theirs.

Recommendations for Future Research

It is recommended that future research examine children's programs nationally for several reasons. First, to understand why approximately 40% of battered women's shelters (NCADV 1986) are not providing children's services. Additionally, to determine whether barriers noted by primarily local shelters are consistent with shelters nationwide. And finally, to understand how barriers may be overcome by the 60% of shelters who do provide children's services, and what their recommendations are.

Another suggestion is that future research examine, through follow up studies, the short and long term effects of the various components within the model program. For instance, determining whether individual treatment is more effective than group, conjoint or family therapy when working with children is important, especially with a limited budget and limited space.

Model programs are difficult to implement (Hughes 1982). However, without an optimal model to strive for, service providers may continually implement interventions

that in the long run may not be effective. We can choose to continue providing a temporary refuge from violence that serves as a band-aid treatment, or we can choose to intervene in a way that impacts children and stops the cycle of violence.

Appendices

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Appendix A

Draft: Components of a Model
Children's Program

A Model Children's Program Within
a Battered Women's Shelter:

Components of a Model Children's Program

I. Medical Exam: Physical examination to assess for malnutrition, neglect, physical and sexual abuse as well as any general illnesses.

A. A complete physical examination (within 24 hours) at a local clinic or hospital designated as qualified and particularly sensitive to the medical needs of children coming from homes where domestic violence has occurred. Accompaniment by an advocate of the shelter is optimally desirable as well as follow-up by shelter staff regarding results of the examination and recommendation of the physician, or

B. Referral to a local clinic or hospital for a physical examination (to be completed within 72 hours), or

C. Referral to a local clinic or hospital for a physical examination (to be completed sometime during the shelter stay).

II. Child Abuse Assessment: Staff working with children need to be trained to understand family dynamics which contribute to the battering, molestation, and neglect of children. They must also be familiar with behaviors abused children may display, dynamics of the abusers, as well as specifically trained in child development.

A. Initial Intake - (within 24 hours) with mother and child to understand the dynamics of their former residence and prior family situation leading to their stay at the shelter. Reporting to child protective services is mandated for any case of suspected or known abuse as indicated by the intake as is a physical exam.

B. Special Interview - with child conducted by a clinical professional trained to assess for child abuse and neglect as well as any other psychopathology (within 72 hours) - preferably provided at the shelter (S) - if not at the shelter at another agency through referral (R).

C. Observation of the Child - during play activities and when interacting with her/his family in order to detect possible abuse or neglect that was not apparent through other means. Referral to CPS upon suspicion of such abuse.

D. Referral to CPS upon the child and mother's departure from the shelter when there is no known change in the prior living situation when may contribute to endangerment of the child.

D. M. Brancato 3/87

Draft 3/87

Components of a Model Children's Program

III. Psychosocial Assessment and Treatment

A. An Initial Intake (within 24 hrs) - designed to formulate an individual plan for each child regarding her/his needs within the shelter, school, care, special diet, etc. The preliminary child abuse assessment, mentioned previously, would optimally be done at this time as well.

B. Play Therapy and/or special time with an assigned person (i.e. Big Brother, Big Sister, child advocate) 2-3 times a week while the children are residing in the shelter. This time should be spent age appropriately and divided accordingly: pre-schoolers, 6-8 year olds, 9-12 year olds, and teenagers.

C. Same as above with special consideration for boys 12 and up.

D. Individual Therapy with children with collateral as well as conjoint visits with mother and siblings as needed to provide necessary intervention and support when indicated by inappropriate behavior or conflict exhibited by children between their mother/siblings at the shelter. These services should optimally be provided at the shelter.

E. Referral to agencies who provide clinical services to children and their families when the above services are not provided at the shelter, or for resolution of problems beyond the shelter staff (e.g. bed-wetting).

F. Child Abuse Prevention Workshops - for children residing at the shelter to empower them and provide them with the necessary resources should they find themselves in an abusive situation.

IV. Educational Plan

A. Collaboration with the school district to allow easy entrance into classrooms for the continued education of children in shelters.

B. Quiet/study time at the shelter to promote constructive study habits.

C. Provision of tutorial services at the shelter for school-age children.

D. Provision of special classes for children in the school setting who are currently residing in the battered women's shelter.

D. M. Brancato 3/87

Draft 3/87

Components of a Model Children's Program

V. Advocacy and Follow-Up Services

A. Continued collaboration with child protective services regarding children reported to them who had resided in the shelter.

B. Contact of prior residents via telephone, letter, shelter visit, or home visit, to assess the effectiveness of the shelter intervention and the status of the child involved.

C. On-going support/therapy groups for children who were prior residents of the shelter.

D. Shelter involvement in a child trauma council that serves as an arena where agencies who deal with children abused and exposed to domestic violence can regularly meet to collaborate, educate each other, and network to ensure sensitive and comprehensive treatment of the children involved in domestic violence.

VI. Strengthening Parents - Support Services

A. Parenting/lifeskills educational groups for mothers with children residing at the shelter.

B. Support groups for mothers residing in the shelter to assist them in dealing with their own anger, feelings of helplessness and motivate them to change their situation for themselves and the welfare of their children.

C. Post-resident support groups and parenting classes.

D. Referral to agencies providing parenting classes and support group services when the shelter is unable to do so.

E. Child care at the shelter for children residing at the shelter whose mothers are seeking jobs or alternative housing.

F. Referral to low cost child care when unavailable at the shelter or for those leaving the shelter.

G. Child abuse prevention workshops for mothers residing in the shelter.

D. M. Brancato 3/87

Draft 3/87

Components of a Model Children's Program

VII. Facilities

A. Shelter space to accommodate entire families with young and older children. For example, provision of cribs for those with infants or toddlers and individual beds for other family members.

B. Separate rooms for older boys (12 and up) accompanying their mothers. These boys would be housed together with a male supervisor/role model.

C. Adequate space for indoor activities for children.

D. Adequate space for outdoor activities for children that is well protected, fenced-in, and always supervised when children are present.

E. Space for children's personal belongings.

F. Bathroom facilities at a level which allows children easy access to its use.

G. Variety of age appropriate equipment indoors and out.

VIII. Other Services

A. Nutrition - provision of proper foods for children.

B. Structured, consistent, and predictable daily scheduling of activities for children. For example: regular meal times, quiet time, arts and crafts time and game time, to facilitate predictability and consistency in the child's daily routine.

C. Adequate staff to supervise all the children when mothers are in support groups and lifeskills workshops.

D. All staff trained in child development and effective communication with children.

E. All staff trained in the special needs of children and their families from diverse cultures and ethnic groups.

D. M. Brancato 3/87

Appendix B

Draft: Model Children's
Program Checklist

DRAFT

Checklist

A Model Children's Program Within
a Battered Women's ShelterI. Medical Exam for Children

Services

Optimum Program Desirable Program Minimum Program *SP

A. Complete Physical
Exam within 24 hrs.

X			
	X		
		X	

B. Referral to a lo-
cal clinic - exam to
be completed within
72 hrs.C. Referral - exam to
be completed before
end of shelter stay.

Comments:

II. Child Abuse Assessment

Services

Optimum Program Desirable Program Minimum Program *SP

A. Initial Intake within
24 hrs.

X			
S	R		
X	X	X	
X	X	X	

B. Special Interview by a
clinical professional with-
in 72 hours at the shelter
(S) or through referral (R).C. Via observation of the
child - referral to CPS
upon suspicion.D. Referral to CPS upon
family's departure from
shelter and return to
abusive situation.

Comments:

DRAFT 3/87

III. Psychosocial Assessment and Treatment

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Initial intake with individualized plan - within 24 hours	X	X	X	
B. Play Therapy and/or special time.	X	X	X	
C. Play Therapy and/or special time with special consideration for boys 12 and up.	X	X		
D. Individual therapy with children - collateral and conjoint visits.	X			
E. Referral to agencies when shelter is unable to provide these services.	X	X	X	
F. Child abuse prevention workshop for children in the shelter.	X			

Comments:

IV. Educational Plan

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Enrollment in School	X	X	X	
B. Study/quiet time.	X	X	X	
C. Tutorial Services	X	X		
D. Special Classes	X			

Comments:

V. Advocacy and Follow-Up Service

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Collaboration with CPS	X	X	X	
B. Contact with prior shelter residents.	X	X		
C. Support/Therapy Groups	X	X		
D. Child Trauma Council	X			

Comments:

VI. Strengthening Parents - Support Services

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Parenting Classes	X	X		
B. Support Groups	X	X		
C. Post-resident groups	X	X		
D. Referral to outside agencies.	X	X	X	
E. Child Care at shelter	X			
F. Referral/Child Care	X	X	X	
G. Child Abuse Prevention Workshops	X			

Comments:

DRAFT 3/87

VII. Facilities

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Family Space	X	X	X	
B. Room for boys 12 and up.	X			
C. Indoor activity space	X	X	X	
D. Outdoor activity space	X	X		
E. Space for children's personal belongings.	X	X		
F. Bathroom facilities for children.	X			
G. Age appropriate equipment.	X	X		

Comments:

VIII. Other Services

Services	Optimum Program	Desirable Program	Minimum Program	*SP
A. Nutritional Services	X	X	X	
B. Structured and predictable activities for children.	X	X		
C. Adequate Staff - Child Care	X			
D. Staff Training in child development and communication.	X	X	X	
E. Staff training regarding ethnic and cultural considerations.	X	X	X	

Comments:

Appendix C
Instructions

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March 5, 1987

XXXXXX
XXXXXXXXXX
XXXXXXXXXXXX, XX XXXXX

Dear XXXXXX,

My name is Debra Brancato and I'm a graduate student in Social Work at California State University, Long Beach. My thesis project examines current research regarding the effects of domestic violence on children as well as interventions utilized to reduce their trauma.

My focus has been on services provided for children within battered women's shelters. Based on previous literature I have developed a draft of a model children's program. A model program checklist and detailed description of the components within the model are enclosed. You'll notice this draft defines the optimal, desirable, and minimal service program.

As a director of a battered women's shelter your input concerning the model will be quite important. Only those who operate shelters could really understand what these special children need and what is feasible to provide. I'd like you to review, critique, and make suggestions regarding the proposed model and identify any barriers you see to implementing such a program. There is also a column provided where I'd like you to indicate those *services provided at your shelter (*SP) that are also components of the model. An "X" in the *SP column that correlates with services listed will be sufficient. In the comment section, after each component, jot your statements about the model draft as well as any children's service your agency offers that is not listed in the model.

It is not necessary for you to return the checklist. Instead, I will be contacting you in the next few days to set-up an interview to discuss your evaluation and recommendations regarding the model.

Once again, I hope you'll be willing to assist me in transforming this draft into a solid model children's program to be implemented in battered women's shelters. Once completed, I'd be happy to share a summary of the final results of my study. Please feel free to contact me at (213) XXX-XXXX should you have any questions. Your participation is greatly appreciated. Thank you.

Sincerely,

Debra M. Brancato
Graduate Student, Social Work

Appendix D
Questions Posed to Experts

Questions for the experts

1. Generally, how do you feel about the model children's program draft as presented?
2. What barriers do you see that prevent implementation of the optimal children's program presented?
3. Are you aware of any cultural or ethnic differences which may affect service delivery of such a program or your current program?
4. How available are your current services for children?
5. Can you make any comments about the model that you feel would assist in improving it?

Appendix E

A Model Children's Program:
Components of the Model

A Model Children's Program For
Battered Women's Shelters:

Components of the Model

I. Medical Exam: Physical examination to assess for general health problems, malnutrition, neglect, and physical abuse. And when deemed necessary upon the discovery or suspicion of sexual abuse - an extensive medical exam for the identification and treatment of such, at a facility in agreement with CPS guidelines. Accompaniment by the child's mother and a shelter advocate would be optimal.

A. A medical examination (within 24 - 72 hours) at the shelter site by a qualified medical doctor or nurse practitioner particularly sensitive to the special needs of children coming from violent homes, or

B. A medical examination (within 24 - 96 hours) at a local clinic or hospital designated as qualified and particularly sensitive to the medical needs of children coming from homes where domestic violence has occurred. Accompaniment by an advocate of the shelter is desirable as well as follow-up by shelter staff regarding results of the examination and recommendations of the physician, or

C. Completion of a health survey form with the mother, child and shelter staff member present. Referral to a local clinic or hospital for a medical examination (to be completed sometime during the shelter stay).

II. Child Abuse Assessment: Staff working with children need to be trained to understand family dynamics which contribute to the battering, molestation, and neglect of children. They must also be familiar with behaviors abused children may display, the dynamics of abusers, as well as specifically trained in child development.

A. Initial Intake - (within 24 - 72 hours) with mother and child to understand the dynamics of their former residence and prior family situation leading to their stay at the shelter. Reporting to child protective services is mandated for any case of suspected or known abuse as indicated by the intake, or through a physical exam.

B. Special Interview - with child conducted by a clinical professional trained to assess for child abuse and neglect as well as other psychopathology (within 72 hrs) - preferably provided at the shelter (S). If not at the shelter at another agency through referral (R).

C. Observation of Child - during play activities and when interacting with her/his family in order to detect possible abuse or neglect that was not apparent through other means. Referral to CPS upon suspicion of such abuse.

D. Referral to CPS upon the child and mother's departure from the shelter when there is no known change in the prior living situation which may contribute to endangerment of the child.

D. M. Brancato 5/87

Components of the Model Children's Program

III. Psychosocial Assessment and Treatment

A. An Initial Intake (within 24-72 hrs) designed to formulate an individual plan for each child regarding her/his needs within the shelter, school, overall care, special diet, etc. The preliminary child abuse assessment, mentioned previously, would optimally be done at this time as well.

B. Play Therapy and/or special time with an assigned person (i.e. Big Brother/Sister, child advocate) while the children are residing in the shelter. This time should be spent age appropriately and divided accordingly: pre-schoolers, 6-8 year old, 9-12 year old, and teenagers. Optimal: 2-3 times a week. Desirable: 1-2 times a week. Minimal: when available.

C. Same as above with special consideration for boys 12 and up.

D. Individual therapy with children, with collateral, family, and/or conjoint visits as needed with mother and siblings. These services should optimally be provided at the shelter (S). A desirable program through referral (R).

E. Support/therapy groups for children during their shelter stay.

F. Individual therapy with children who are known to have been abused. Provided at least once a week in the shelter setting (S), or through referral (R).

G. Referral to agencies who provide clinical services to children and their families when the above services are not provided at the shelter, as clients depart from the shelter, or for resolution of problems beyond the shelter staff expertise (e.g. bedwetting).

H. Content specific workshops on child abuse prevention and alcohol awareness - for children residing at the shelter to empower them and provide them with the necessary resources.

I. Infant Stimulation Groups - service provided by carefully screened volunteers in the community, shelter residents, or child development students at local universities to enhance the development of the infants while their mother works through her recent trauma.

D. M. Brancato 5/87

Components of the Model Children's Program

IV. Educational Plan

A. Provision of an on-site school program by a credentialed teacher for children of all ages who are currently residing in the battered women's shelter. This service would be provided as an alternative to attending a community school.

B. Collaboration with the school district to allow easy entrance into classrooms for the continued education of children in shelters.

C. Provision of annual in-services in school settings for staff and personnel.

D. Quiet/study time at the shelter to promote constructive study habits and modeling of alternative ways to spend time (such as reading) besides watching television.

E. Provision of tutorial services at the shelter for school-age children.

F. Provision of on-site preschool staffed by employees or mothers residing in the shelter.

V. Advocacy and Follow-Up Services

A. Continued collaboration with CPS regarding children reported to them who had resided in the shelter.

B. Contact with prior residents via telephone, letter, shelter visit, special events, or home visit, to assess the effectiveness of the shelter intervention and the status of the child involved.

C. On-going support/therapy groups for children who were prior residents of the shelter.

D. Shelter involvement in a social service coordinating council or child trauma council that serves as an arena where agencies who deal with children abused and exposed to domestic violence can regularly meet to collaborate, educate each other, and network to ensure sensitive and comprehensive treatment of the children involved.

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Components of the Model Children's Program

VI. Strengthening Parents - Support Services

- A. Parenting/lifeskills education groups for mothers with children residing at the shelter.
- B. Support groups for mothers residing in the shelter designed to: empower them; assist them in dealing with their feelings of anger and helplessness; and motivate them to change their situation for themselves and the welfare of their children.
- C. Post-resident support groups and parenting classes to reinforce skills learned and reduce parental isolation.
- D. Referral to agencies providing parenting classes and support group services when the shelter is unable to do so.
- E. Provision of low-cost licensed day care for residents.
- F. Child care for children residing at the shelter whose mothers are seeking jobs or alternative housing, through the assistance of other mothers at the shelter and supervised by shelter staff.
- G. Referral to low cost child care when unavailable at the shelter or for those leaving the shelter.
- H. Content specific workshops on child abuse prevention and alcohol awareness.
- I. Job Training - provided at the shelter (S), or through referral (R).
- J. Referrals for low cost housing

VII. Facilities

- A. Family space which accommodates young and older children, for example, provision of cribs for those with infants or toddlers and individual beds for other family members.
- B. Separate rooms for older boys (12 and up) accompanying their mothers. These boys would be housed together with a male supervisor/role model.
- C. Adequate space for indoor activities for children.
- D. Adequate space for outdoor activities for children that is well protected, fenced-in, and always supervised when children are present.

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Components of the Model Children's Program

VII. Facilities (Continued)

- E. Space for children's personal belongings.
- F. Bathroom facilities at a level which allows children easy access to its use.
- G. Variety of age appropriate equipment indoors and out.
- H. Facility able to meet regulations and standards of licensed day care program in the event this service is offered.
- I. Handicap accessibility with special provisions throughout the shelter.

VIII. Other Services

- A. Nutrition - provision of proper foods for children and nutritional counseling for parents regarding their child's diet.
- B. Structured, consistent, and predictable daily scheduling of activities for children, for example: regular meal times, quiet time, arts and crafts time, game time, and after school programs, to facilitate predictability and consistency in the child's daily routine.
- C. Supervision of the children while mothers are in support groups and lifeskills workshops.
- D. All staff trained in child development and effective communication with children.
- E. All staff trained in the special needs of children and their families from diverse cultures and ethnic groups.

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Appendix F

A Model Children's Program:
Program Checklist

**A Model Children's Program For
Battered Women's Shelters:**

Program Checklist

I. Medical Exam For Children

Services	Optimal Program	Desirable Program	Minimal Program
A. Medical Exam, on-site, within 24-72 hours.	X		
B. Referral to a local clinic for a medical exam to be completed within 24-96 hours.		X	
C. Health survey form, referral to a local clinic for a medical exam to be completed sometime during the shelter stay.			X

II. Child Abuse Assessment

Services	Optimal Program	Desirable Program	Minimal Program
A. Initial intake within 24-72 hours.	X		
B. Special interview w/clinical professional within 72 hrs at the shelter (S) or through referral (R).	(S)	(R)	
C. Via observation of the child.	X	X	X
D. Referral to CPS upon the family's departure and return to abusive situation.	X	X	X

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A Model Children's Program For
Battered Women's Shelters:

Program Checklist

III. Psychosocial Assessment and Treatment

Services	Optimal Program	Desirable Program	Minimal Program
A. Initial intake w/individualized plan - within 24-72 hours.	X	X	X
B. Play therapy and/or special time.	X	X	X
C. Play therapy and/or special time with boys 12 year old and up.	2-3x's	1-2x's	as available
D. Individual therapy w/children--collateral and conjoint visits as needed.	X		
E. Support/therapy groups or therapeutic activity groups	X	X	X
F. Individual therapy for abused children--collateral and conjoint sessions as needed.	X	X	
G. Referral to agencies when shelter is unable to provide above services.	X	X	X
H. Content specific workshops on child abuse prevention & alcohol awareness.	X		
I. Infant stimulation groups.	X		

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**A Model Children's Program For
Battered Women's Shelters:**

Program Checklist

IV. Educational Services

Services	Optimal Program	Desirable Program	Minimal Program
A. On-site school program.	X		
B. Enrollment in a community school.	X	X	X
C. Annual in-services for school staff and personnel.	X	X	
D. Quiet/study time	X	X	X
E. Tutorial services	X	X	
F. On-site preschool	X	X	X

V. Advocacy and Follow Up Services

Services	Optimal Program	Desirable Program	Minimal Program
A. Collaboration with CPS.	X	X	X
B. Contact w/prior shelter residents.	X		
C. On-going support therapy groups for children post-resident stay.	X	X	
D. Shelter involvement in a social service coordinating council.	X	X	X

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A Model Children's Program For
Battered Women's Shelters.

Program Checklist

VI. Strengthening Parents - Support Services

Services	Optimal Program	Desirable Program	Minimal Program
A. Parenting life-skills training.	X	X	X
B. Support Groups	X	X	X
C. Post-resident groups	X	X	
D. Referral to agencies when shelter are unable to provide the services.	X	X	X
E. Licensed Day Care at the shelter facility.	X		
F. Child care at shelter.	X	X	X
G. Referral/child care.	X	X	X
H. Content specific workshops on child abuse prevention and alcohol awareness.	X	X	
I. Job Training at shelter (S), through referral (R).	(S)	(R)	(R)
J. Referrals/low cost housing.	X	X	X

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**A Model Children's Program For
Battered Women's Shelters:**

Program Checklist

VII. Facilities

Services	Optimal Program	Desirable Program	Minimal Program
A. Family Space	X	X	X
B. Room for boys 12 & up.	X	X	
C. Indoor activity space.	X	X	X
D. Outdoor activity space.	X	X	X
E. Space for children's belongings.	X	X	
F. Bathroom facilities for children.	X	X	
G. Age appropriate equipment.	X	X	X
H. Standards according to licensed day care.	X		
I. Handicap accessibility.	X	X	

VIII. Other Services

Services	Optimal Program	Desirable Program	Minimal Program
A. Nutritional Services.	X	X	X
B. Structured and predictable activities for kids.	X	X	
C. Adequate supervision of children.	X	X	
D. Formal staff training in child development and communication.	X	X	X
E. Formal staff training in cross-cultural issues relative to battering & childrearing.	X	X	X

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